❑ Initiate Waiver services
❑ Service Modification
  □ Add a service
  □ Increasing hours of service
  □ Decreasing hours of service
❑ Change in SF (requires 2 ISARs)
❑ End CD Service

MR Waiver
Consumer-Directed Companion Services
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Name: _____ Medicaid No. _____
Last, First MI

Address: _____
Street/Apt. City, State Zip Code

Phone No. _____ Social Security No. _____

Patient Pay Amount: $_____ Is this service designated to collect patient pay? ☐Yes ☐No ☐N/A

_____ _____ Reassessment? Y_____ N_____
Services Facilitator (SF) Provider No.
SF agency, if applicable Individual is 18 or older Yes ____ No ____

Will the individual be directing his or her own services? ☐ Yes ☐ No

If NO, name and relationship of responsible family member/caregiver:

SERVICE REQUESTED	WEEKLY / YEARLY HOURS	OMR USE ONLY
Fill in applicable dates: **CD Companion** services start date may not precede: SF Start Date: _____ SF End Date: _____ S5136--CD Companion Start Date: _____ S5136--CD Companion End Date: _____ Total # of persons with disabilities in the residence_____	_____ Hours / week x 52 = _____ Yearly total	

Reason for this request: _____

Check the allowable activities included in the individual's ISP. Indicate the *total* number of hours *per day* of expected CD Companion services.

Assistance or support with	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
☐ tasks such as meal preparation, laundry and shopping							
☐ light housekeeping tasks							
☐ self-administration of medication							
☐ community access and recreational activities							
☐ health and safety							

Comments:

List any other currently authorized AD or CD Companion services providers:

Assurance that total of all AD and CD Companion services hours does not exceed 8 hrs in any 24hr. period. ☐ yes ☐ no

_____ _____
Signature of Services Facilitator Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

_____ _____ _____
CSB Rep/ Case Manager (print) Phone No. Fax No.

_____ _____
Signature Date

DMAS-427 Rev. 8/04